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SEPTEMBER—OCTOBER 1993

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From the Editors

The first time one of us ever went into an operating room was as a teenager, to observe an anterior lumbar fusion being performed by a general surgeon in a small town hospital. The patient was discharged from the hospital eight weeks later with some lessening of his chronic back pain and lighter by twenty pounds or so. During residency, one of us took care of an elderly gentleman who had undergone a total hip replacement and had to have the device removed, and ultimately his leg amputated, because of sepsis. In this issue area orthopedic surgeons have contributed perspectives on their specialty. Despite the tremendous advances, orthopedics suffers from the fact that because common-sense expectations in this area frequently exceed what is possible, litigation has driven malpractice rates through the roof. This in turn reduces the numbers of orthopedists performing these "miracles" of medicine—and ultimately denies many access to treatments which can greatly improve quality of life.■

Brigid Glackin, M.D.
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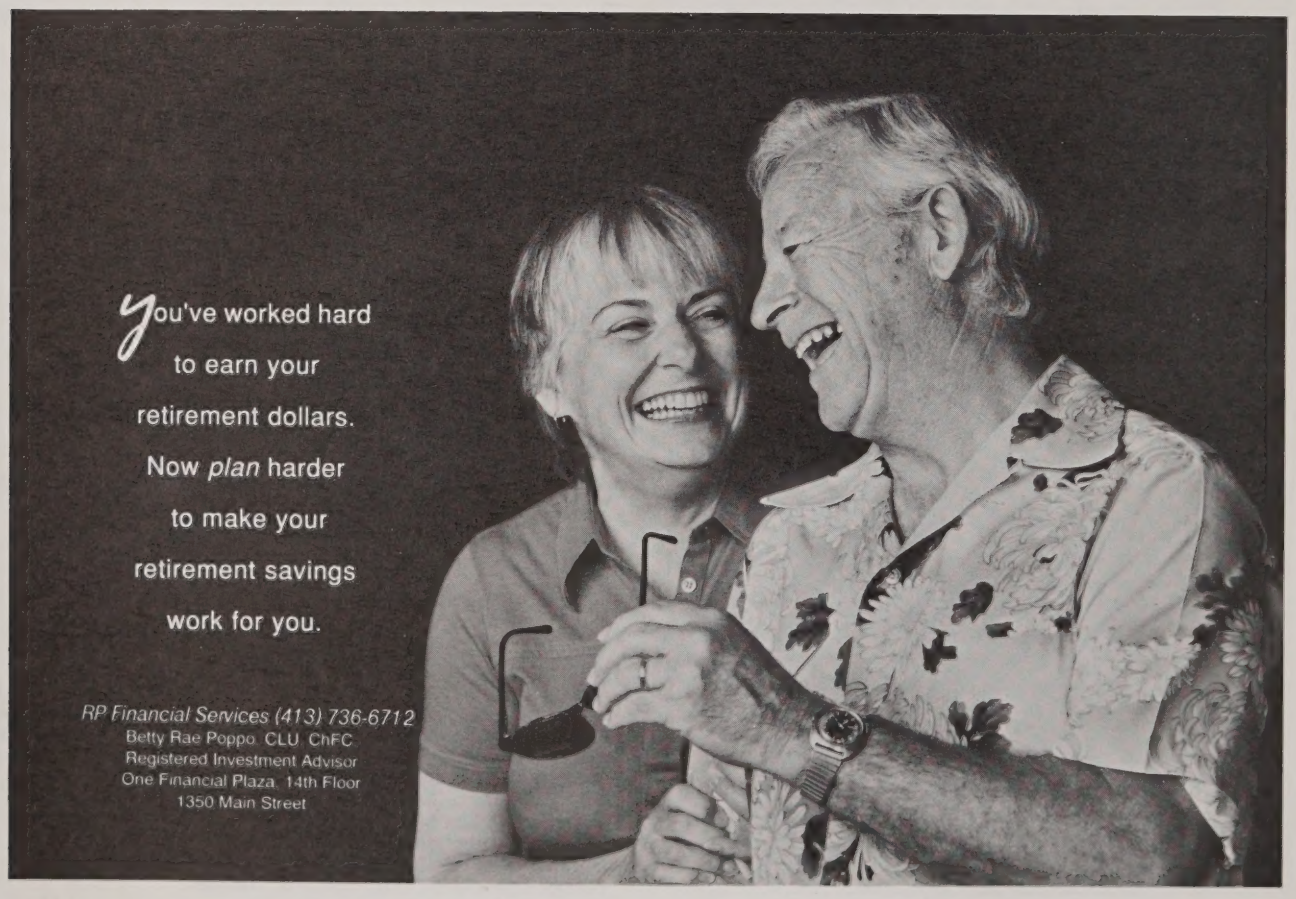

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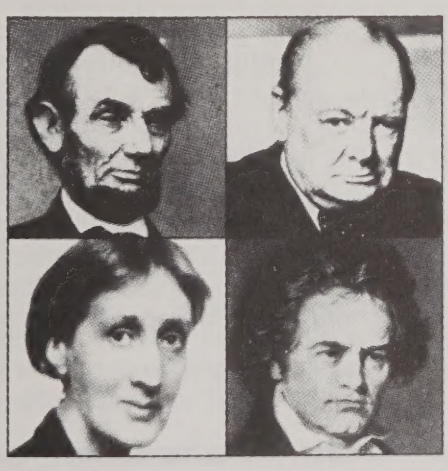

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Are Physicians Holistic?

It is well recognized that a large segment of our population seeks care with alternative health systems instead of or, in addition to, our traditional medical structure. Many of these alternative systems have adopted the term "holistic" as a lynch pin of their approach to health to clearly separate themselves from traditional medicine. Holistic in this context refers to the emphasis on the augmentation of the well being of the entire organism bringing it into greater harmony with its environment. These approaches separate themselves from traditional medicine which is pictured as concentrating on disease to the diminution of the importance of the individual's well being. In practice these disciplines spend little energy on taxonomy, etiology or pathophysiology emphasizing instead the therapeutic potential of the individual working together with the environment utilizing principles of nutrition, botany, meditation or physical therapy to strengthen the individual and overcome his malady.

Francis D. Horrigan, M.D., President

The relationship of these "holistic" disciplines to society differs from that of traditional medicine. Society has often accepted, tolerated and encouraged these disciplines recognizing roots in ancient mysticism or fascinated by new applications of old phenomena. Systems with roots in magnetism or early theories of electricity are examples. Interestingly there is very little demand for proof of efficacy (or safety) from these systems. Often a few testimonials will do. Their continuing popularity in our culture indicates that they do indeed fill a need. Several of these disciplines have evolved to the point of approaching what

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is considered "traditional" care. Many are based in theories that allow scientific evaluation while others approach a nearly religious identity.

People who seek these approaches often feel underserved by traditional medicine emphasizing a sense of insufficient recognition of the entire person. They are quick to point to the sizeable gaps in our knowledge and to the unpleasant or even dangerous aspects of our therapies. Such people may see physicians as arrogant, imposing treatments without respect to patient's individuality, culture or value systems as well as in rejecting as worthless any theory that has not passed "scientific" muster.

On the other hand society has granted the physician the role and responsibility as the preeminent guardian of its health. Traditional medicine brings to bear literally millenia of experience, study and accomplishment to the improvement of the health of our patients. The scientific approach to health problems is labor intensive and maddeningly plodding but ultimately accurate and definitive. Society demands of us proof of accuracy, safety, efficiency and efficacy to the point of sanctions if these are not accomplished. It is sometimes easy to become so distracted by the technical process of diagnosis and treatment as to appear oblivious to the (holistic) patient.

I maintain that physicians are "holistic" and reject the image of the dispassionate authoritarian healer with more concern for structures and outcomes than for people. The physicians I know became so precisely because they do care and want to make people better. The physician has the training and experience to bring to the patient not only medical science but also people expert in nursing, pharmacy, nutrition, physical therapy and pastoral needs in one place at one time. The physicians I know can be seen at all hours, regardless of personal stress or fatigue, delivering compassionate care to their patients, comforting the dying and encouraging concerned loved ones.

Yes, physicians are holistic. ■

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Halina Wiczyk, M.D., Chief of Reproductive Endocrinology, Department of Obstetrics & Gynecology announces that

Daniel Grow, M.D.
& Donna O'Shea, M.D.

have joined the full time faculty of the Department of Obstetrics & Gynecology at Baystate Medical Center. Drs. Grow and O'Shea's practice concentration will be in the subspecialty of **Reproductive Endocrinology**, including:

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Dr. Grow received his medical degree from Pennsylvania State University Medical School, completed residency training in Ob/Gyn at York Hospital in Pennsylvania, and completed a two year fellowship in reproductive endocrinology and infertility at the Jones Institute for Reproductive Medicine at Eastern Virginia Medical School.

Dr. O'Shea received her medical degree from the University of Rochester School of Medicine, completed residency training in Ob/Gyn at University of Iowa Hospitals and Clinics, and completed a two year fellowship in reproductive endocrinology and infertility at Washington University School of Medicine.

Both physicians serve on the faculty of Tufts University School of Medicine, and are members of the American College of Obstetrics & Gynecology and the American Fertility Society.

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Total Joint Arthroplasty

Richard J. Fingeroth, M.D., and Robert J. Krushell, M.D., of New England Orthopedic Surgeons, contributed the following.

Arthritis is one of the major causes of disability in the twentieth century affecting 50% of people over the age of fifty. In most people symptoms can be controlled with conservative measures including medication, physical therapy, weight reduction, bracing, ambulatory aids and occasional injections. Prior to the advent of total joint replacement, surgical options available to those people with severe arthritis were limited to resection arthroplasty, osteotomy, fusion, and amputation. In 1940 Dr. Moore performed the first hip hemiarthroplasty; his component is still used today for hip fractures in low demand patients. Sir John Charnley performed the first modern total hip replacement in 1962 and is credited with the introduction of high molecular weight polyethylene and the use of methylmethacrylate (burrowed from dentistry) for component fixation to bone. In 1970 Mr. Gunston, working in Sir Charnley's lab, developed the first resurfacing knee replacement. The field has since mushroomed with more than 400,000 hip and knee replacements being done in this country last year. Secondary to better access to health care, increased patient awareness, a growing older population, documented cost effectiveness, and a success rate of greater than 95%, the number of joint replacement is growing by 10% a year. With the founding of The Association for Arthritis Hip and Knee Surgery in 1991, joint replacement surgery is now recognized as a bonafide sub-specialty of orthopedic surgery.

"Most joint replacement surgeons would agree that Bo Jackson was a terrible candidate for joint replacement."

Significant pain unresponsive to conservative treatment remains the primary indication for total joint replacement. This usually means pain which awakens the patient from sleep, limits ambulation to less than two blocks and interferes with simple activities of daily living. Older, less active patients are the best candidates and indeed, several studies have shown that patients over the age of eighty do well with this surgery with only a slight increase in perioperative morbidity. With improved technique and better components the lower age limit has steadily decreased but there is a real concern regarding the longevity of the joint replacement in patients less than fifty years old. Activity level following surgery is important and patients with limited activity secondary to multiple joint involvement (for example severe rheumatoid arthritis) are reasonable candidates for a joint replacement at a much younger age. Non impact activities such as swimming, bicycle riding, walking and golf are encouraged after surgery, but impact activities such as tennis, running, or jogging need to be avoided since they are likely to increase the rate of loosening and wear. Most joint replacement surgeons would agree that Bo Jackson was a terrible candidate for joint replacement.

The potential complications of total joint replacement are now well understood. Infection is perhaps the most devastating complication since it usually necessitates removal of the components. In the 1970's the infection rate with total hip replacement was 13%. The introduction of perioperative antibiotics decreased this to 1-2%. Compulsive attention to sterile technique, special environment operating rooms

(ultraviolet light; laminar flow) and the use of body exhaust systems for the operative team have lowered the primary infection rate to .1% at most major centers such as Baystate Medical Center. A biocalyx forms around the metal components creating a protective environment for bacteria. This makes secondary infections spreading from elsewhere in the body a real problem, necessitating the use of prophylactic antibiotics for any procedure that can be associated with a bacteremia as well as aggressive and prompt treatment without some type of prophylaxis the incidence of deep vein thrombosis following total joint surgery is 50% with a 2% incidence of fatal pulmonary emboli. Subcutaneous Heparin has proven to be ineffective and aspirin has had variable results. Low dose Coumadin started in the perioperative period, keeping the Protime between 15 and 16, in combination with mechanical prophylaxis such as compression boots and early ambulation have lowered the incidence of deep vein thrombosis to 15% with no fatal emboli. At Baystate Medical Center we use post operative Doppler ultrasound to decide how long to continue the Coumadin.

Component loosening often leads to pain and bone loss and necessitates surgical revision. With early cementing techniques the incidence of loosening was 30% at ten years. This problem has been approached in two very different ways. On the one hand, an attempt has been made to eliminate cement by using press fit porous with hydroxyapatite coated prostheses hoping for a biologic fixation which could remodel with time and maintain component stability. On the other hand, this problem has been addressed by developing better cementing techniques including centrifugation and pressurization of the cement. These newer cementing techniques work well with total knee replacement which is done under tourniquet control and with the femoral component in total hip replacement. There is, however, still a high failure rate with cemented acetabular components. Although this issue is far from being resolved, there is growing consensus that all knee replacements be cemented, that all acetabula be uncemented and that femoral

Continued on next page

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Total Joint Arthroplasty

Continued from previous page

components in total hip replacemtns be either cemented or uncemented depending on bone quality and the patient's age. Since radiologic loosening occurs before clinical symptoms develop, yearly follow up is necessary, thus, the total joint surgeon establishes a life long relationship with his patients.

With the newer metals (cobalt-chrome or titanium) component breakage is no longer a problem. The routine use of autologous blood donation as well as the use of post operative salvage systems have eliminated the need for blood bank transfusions. The problem of heterotopic bone, which can be as high as 80% in those patients who are at increased risk, has been successfully controlled with either low dose post operative irradiation (600 rads) or a six week post operative course of Indocin. The incidence of dislocation in total hip replacement surgery is 5% nationwide. At BMC aggressive patient education regarding proper positioning with activities of daily living has lowered this to 1%. The routine use of regional anesthesia (usually epidural with a light general) has significantly decreased perioperative morbidity. The epidural catheter is also used for post operative pain control.

The generation of particulate debris from cement, plastic and metal does remain a significant problem. Although allergic reactions have not been an issue, some of these particles are toxic and all of them can incite a biologic response characterized by the release of inflammatory mediators which lead to bone resorption. This phenomena is being described with increasing frequency and promises to be one of the main concerns in total joint surgery in the nineties. Active research is in progress at multiple centers looking for better materials as well as medical inhibitors to block this inflammatory reaction.

As is true elsewhere in medicine, cost is an overriding concern in total joint surgery. Every effort is being made to minimize cost without sacrificing quality of care. Several studies have shown total joint replacement surgery to be cost effective in returning people to independent and productive lives. Less high tech (and less expensive) components are being used in older patients with lower demands. Hospital stay has been decreased from two weeks in 1985 to 5-6 days today. The cost versus benefit of everything done in association with this surgery has been looked at closely. One of the results of this has been the elimination of the use of the cell saver for routine total joint replacements since it was shown not to be cost effective. The issue of cost control promises to be of increasing importance.

Total joint surgery has made tremendous strides over the past twenty years. Greater than 95% of surviving patients can expect their total joint replacement to be functioning well at ten years. New techniques and components presently being used will most certainly improve the 85% success rate being reported at twenty years. The reliable relief from pain and the restoration of morbility make total joint replacement one of the medical miracles of the twentieth century. ■

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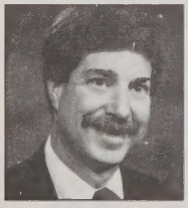

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The Spine Fusion Program at Baystate Medical Center

Marc A. Linson, M.D. is in the private practice of orthopedic and spine surgery, and has been a major force in the development of the spine fusion program.

Upon my return from work at the London Clinic in England in 1985, a serious program of spinal fusion for back pain was developed at the Baystate Medical Center. Using diagnostic tools and surgical therapies originally promoted by Mr. John O'Brien in England, and at the time only used to any great degree in Dallas and San Francisco, we embarked on identifying patients who might be helped with surgical treatment for back pain specifically by fusion. At that time leg pain would traditionally be treated with decompressive procedures such as disc excision or laminectomy, but patients with incapacitating back pain were often felt to have the source too elusive, and that modalities of treatment then available were too unpredictable to offer any hope to them. Discography, which is the technique of inserting a needle into the disc to inject it with dye and reproduce pain, was the test used to identify most patients who, after failure of prolonged conservative care with severe persistent unlivable back problems, might then proceed for fusion.

Baystate Medical Center now ranks nationally as a focus for spine fusion, with many hundreds of cases per year.

A team of "discotechs" was developed in the x-ray department originally at the Wesson Memorial Hospital and later at the Baystate Medical Center North Campus. Testing would occur at all suspect levels of the spine in order to identify pain source. By 1987 the MRI scan was sufficiently developed that it was possible to identify which disc would be most suspicious for production of pain by T2 images. Christopher Crowe of the radiology department and myself published our work a number of years later in Clinical Orthopedics and Related Research delineating that only those discs which came out "dark" on T2 images would be likely suspects for pain production. Normal "bright" discs on T2 weighted image MRI scans had such a low yield that we have since abandoned discography at those levels.

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Once the patient's pain source is identified we then were proceeding with a fusion in selected patients. From 1986 through 1989 anterior fusion was the main technique used because of its much greater degree of reliability in terms of reducing deformity and gaining solid fusion over the more traditional uninstrumented posterior fusions then available. Single levels were done from the front only with an approximate 70% fusion rate and multiple levels are done by a front and back procedure with approximately the same success rate overall. In 1990 the preliminary results of the first few years of work along these lines was published in SPINE with an overall 80% success rate for pain improvement for a two year follow-up. Herman Williams who visited with us from Boston University Medical School in 1989 was instrumental in collating the data and preparing the report for publication.

Another major advance occurred in 1989 with the advent of the pedicle screws which were then available through the Spinal Fixation Study Group in Baltimore, Maryland. This highly advanced equipment allowed for enhanced reduction of deformity and improved fusion rates, both by a posterior approach. Over time this has allowed me to reduce the need to do interbody fusions from an anterior approach and to achieve much of the same goals at a nearly comparable success rate through a posterior operation.

We are now in the process of evaluating a five year long term follow-up of the original series of anterior interbody fusions (uninstrumented) and at the same time taking a closer look at the comparative results of the posterior instrumented pedicle screw fixation using the Edward system from Baltimore. The results seem roughly comparable so that the original concept of "anterior fusion for back pain" can be simplified to "fusion for back pain" with the specific technique being optional as either anterior, posterior, or both. Baystate Medical Center now ranks nationally as a focus for spine fusion, with many hundreds of cases per year.

As a next step the future seems to hold great interest and enthusiasm for the artificial discs which are now being developed in many centers. It is anticipated that these will be inserted through an anterior approach and may in some way offer many of the benefits of fusion but without loss of motion at that segment and without the potential for transfer of stress and strain to adjacent levels of the spine. It is certain that this will be a highly interesting period of investigation as we continue our understanding of the surgical treatment of disc disease and its impact on back pain. ■

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The Shriners: Hope On The Hill

John M. Roberts, M.D., who contributed the following, is Chief of Staff at Shriners Hospital in Springfield.

The Shriners Hospital for Crippled Children on Carew Street in Springfield has been in continuous operation since 1925. The current, modern facility was occupied in 1990. Even then, Shriners did not break step. A resident orthopaedic surgeon said at the time: "I can't believe we just finished out-patient clinic in the old building and we are now, minutes later, making in-patient rounds in the new building!" Within weeks, the old building had disappeared, victim of a giant backhoe, but not without leaving a legacy of excellence in the treatment of children with orthopaedic deformities. And even now remaining unique in that no payment of any kind is received for services rendered. The work of the Springfield Unit and its twenty one sister institutions thoughout North America is completely supported by the International Shrine organization and Shriners fraternity.

The past and present traditions of the place are traced by the patients who are treated and the staff who have worked there.

There have been two major phases in the development of treatment programs at Shriners Hospitals, which are now on the brink of yet a third period in their history. In the beginning, the hospitals were established to respond to the tremendous needs of thousands of children afflicted with infections of the musculoskeletal system: tuberculous joints, hamatogenous osteomyelitis and chronic poliomyelitis. The first phase ended with the development of antibiotics and the polio vaccine. In the second phase, from the 1950's through the 1980's, the hospitals were taking care of children whose families could not afford the rapidly increasing costs of long term hospitalization required for the treatment of conditions such as leg length discrepancy, Legg-Perthes disease, and scoliosis.

Presently, with universal access to health care in sight, the Springfield Unit prepares for a role as resource for the treatment of uncommon deformities and for conditions which may not be treated well elsewhere, because of containment of funding and/or lack of experience. The medical staff has expanded to include four full time pediatric orthopaedists with active support from eleven orthopaedic subspecialists, and fifty five consulting pediatric subspecialists from the community. Specialty clinics have been established for the evaluation and treatment of hip disorders, clubfoot, scoliosis and other spine deformities, hand deformities, neuromuscular disorders, limb deficiencies, myelogysplasia, arthritis, as well as metabolic and genetic conditions relating to the musculoskeletal system.

In the Shriners Hospital System, the defined referral base for the Springfield Unit is all of New England and upper New York State, the area between similar hospitals to the north in Montreal, to the south in Philadelphia and to the west in Erie, Pennsylvania, Many patients are local, but others in the north country of Maine or upper New York State face as much as an eight hour drive to come for evalulation, treatment or follow-up. Therefore, annual or semi-annual out-reach clinics have been established in locations as diverse as Bangor, Maine, Utica, New York, and San Juan, Puerto Rico.

The Springfield Unit is affiliated with Boston University and Columbia University medical schools. Orthopaedic residents and medical students rotate through the hospital for experience in pediatric orthopaedics. A post-residency fellowship program has also been established. Increasingly, the teaching of intellectual skills such as analysis of collected data, consideration of treatment alternatives and decision making is considered a responsibility of the attending staff

faculty because the students and residents have the unique opportunity to work up patients the day before surgery, participate in the surgery and follow the cases thereafter. The continuity of case oriented learning is still possible at the Shriners Hospital, whereas it may be precluded by in-and-out stays of patients in many other teaching hospitals. Each day begins with a conference and teaching rounds, supplemented by monthly visits of speakers with national and international reputations. There is mutually beneficial collaboration in the teaching schedule with the Division of Orthopaedic Surgery at the Baystate Medical Center.

Clinical and basic research related to the musculoskeletal system in children is ongoing. The research unit of the in-house Department of Orthotics and Prosthetics has produced new lighter materials for artificial limbs, including a longer lasting miniaturized battery to motor terminal devices when switched on through transmitters responding to muscle action in the patient's amputation stump. A computer aided design/computer aided manufacturing system has been developed for prostheses in children; three dimensional modeling has facilitated greatly the modification of sockets for prostheses. In the state-of-the-art Gait Analysis Laboratory, children with deformities of the lower extremities and motion disorders are studied before and after treatment, thereby providing accurate documentation for clinical outcome studies. Additionally, study of trunk balance in scoliosis and foot power in clubfoot have brought about refinements in operative and non-operative treatment in both of these conditions. The rather focused data base of a specialty hospital such as Shriners is a fertile field to till for clinical research in pediatic orthopaedics.

The past and present traditions of the place are traced by the patients who are treated and by the staff who have worked there. A former resident in orthopaedic surgery who has since become a departmental chairman and professor of orthopaedics at the University of Ottawa has written some memoirs which, among other experiences in his rotation to Springfield, described the treatment of "manure septicemia" in the lion tamer who got mauled at the Shriners circus. Recently, a sixty six year old visitor reminisced about his days as a patient treated for tuberculosis of the hip and then boasted that during this active adult life he has refereed more than 15,000 basketball games. A letter from another former patient recalls fondly the first Chief Surgeon, Nelson Hatt, M.D., who was much respected, and tells about the president of the Indian Motorcyle Co. bringing balloons every Saturday. Yet another former patient credits Drs. Katz and Kruger for giving her a leg to walk on for forty five years as a school teacher. The hospital continues to hold fast to the concept that improving the world of children will help improve the world. ■

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Utilizing HIV-Positive Faculty In Continuing Medical Education

Jack Starmer, the Assistant Director of the New England AIDS Education and Training Center, describes a unique upcoming course for practitioners.

It has been said that our patients are our best teachers, and the New England AIDS Education and Training center (ETC), has taken this notion to heart by utilizing people living with HIV as "resource faculty" for the past five years. One of seventeen federally funded AIDS Education and Training Centers, the ETC was created to meet the needs of primary care physicians for state-of-the-art HIV/AIDS information and to increase the base of providers caring for patients with HIV disease. Since its inception, thousands of providers and medical students in the six state region have participated in ETC conferences, mini-residencies, courses, and other training opportunities and the evaluations have consistently cited our HIV-positive faculty as our most important resource.

At the invitation of western Massachusetts providers who have participated in its programs, the ETC will be offering "Care and Management of the HIV/AIDS patient: A course for Primary Care Providers" on November 4-6, 1993, in Enfield, Connecticut, 15 miles south of Springfield. This two and one-half day course represents one of the most successful ETC models by blending focused didactic sessions with periods for small group discussion with our HIV-positive faculty. The plenary sessions stress the spectrum of clinician-patient interactions, including risk assessment, testing and counseling, ambulatory care and management of HIV, management of end-stage disease, new therapies and research, health care worker risk, substance use and HIV "Living and Dying", and legal/ethical issues. The small group sessions give participants an opportunity to explore the emotional impact of caring for people with HIV disease and to share personal and professional concerns in a supportive setting. It is within this context that the resource faculty have made their most significant contributions.

The New England AIDS Education and Training Center is sponsored by the Office of Community Programs, UMass Medical Center, and offers CME credits through UMass Medical School. This upcoming program is cosponsored by the Berkshire Area Health Education Center. For more information on this course or other ETC programs, please call 617-735-2048. ■

— REGISTRATION —

"Care and Management of the HIV/AIDS Patient: A Course For Primary Care Providers"

Thursday, November 4 through Saturday, November 6, 1993

Name: _____

Title: _____ Affiliation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please indicate your clinical discipline:

☐ Physician ☐ Nurse Practitioner ☐ Other (specify)

☐ Physician Assistant ☐ Nurse _____

NOTE: In that our goal is to train primary care professionals in providing HIV care as a teaching resource for your colleagues or students, we request a letter describing your present and previous involvement in HIV care, especially teaching about various aspects of HIV.

Please return this form with a check made payable to UMMS by October 25, 1993 to:
University of Mass Medical School, C/O School Bursar, 55 Lake Avenue North, Worcester, MA 01655

New Members Welcome

Barry J. Karas, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 2, 1955
Premed: Northeastern University 1973-1978
University of Florida 1978-1980
Medical: University of Autonoma de Guadalajara 1982-1985
New York Medical College 1985-1988
Internship: Baystate Medical Center 1988-1989
Residency: Baystate Medical Center 1989-1991
Fellowship: Baystate Medical Center 1991-Present
Specialty: Internal Medicine/Cardiology
Fellow

Ronald N. Paasch, M.D.
201 Park Avenue
West Springfield, MA 01089

Born: April 22, 1961
Premed: Cornell University 1979-1983
Medical: WMDNJ-Rutgers Medical School, NJ 1983-1987
Internship: UCI Medical Center, California 1987-1988
Residency: UCI Medical Center 1988-1991
Specialty: Physical Medicine and Rehabilitation

William J. Dean, III, M.D.
10 Hospital Drive
Holyoke, MA 01040

Born: February 1, 1960
Premed: College of the Holy Cross 1979-1983
Medical: New York Medical College 1984-1988
Internship: Berkshire Medical Center 1988-1989
Residency: Medical Center Hospital of Vermont 1989-1992
Specialty: Neurology

Cheryl A. Geoffrion, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: April 8, 1963
Premed: Mount Holyoke College, MA 1981-1985
Medical: University of Vermont College of Medicine 1989-1993
Internship: Baystate Medical Center, 1993-Present
Specialty: Internal Medicine
Intern

Jules F. Levey, M.D.
70 Court Street
Westfield, MA 01085

Born: November 9, 1943
Premed: Wayne State, Michigan 1966
Medical: Wayne State University School of Medicine 1970
Internship: Mt. Carmel, Detroit, Michigan 1970-1971
Residency: Mt. Carmel, Detroit, Michigan 1971-1975
Specialty: General Surgery

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Charles A. Atamian, M.D., Writes...

On retirement, forget about malpractice insurance, and government interference, select a third world country and work with their physicians. As director of the cancer program for 20 years at Mercy Hospital and 40 plus years of surgical oncology experience, I selected Armenia, where I have worked with the staff of the Oncology Institute in Yerevan.

Not only have I had the opportunity to see numerous complicated cancer patients in consulation, lecture to the staff, and perform surgery, but I have had the privilege of working with Professor Levon Mkrtchian who was once offered the top oncology position in the former USSR by Gorbochov. The professor has developed chalones for treating breast, pancreatic, and liver cancer.

On my recent tour of the Institute, I participated in the treatment of two patients with breast cancer. A paper has been submitted for publication.

My second tour was better than the first because my wife accompanied me. She taught English to some of the staff. Also my exposure to Russian has allowed me to improve my knowledge of that language.

For you 65 year olds, select a third world country and put your knowledge toward the continued benefit of mankind. ■

In Memoriam

Benjamin L. Gipstein, M.D., passed away on August 8, 1993. A graduate of the former Middlesex Medical School in Boston, he was chief of Obstetrics and Gynecology at Mercy Hospital. He was a founding member of Sinai Temple, and past president of its Brotherhood. He leaves his wife, Dorothy, a son, Robert, and a daughter, Gail.

Harry N. Memery, M.D., expired on August 25, 1993. Dr Memery graduated from Tufts University Medical School and after serving in the Air Force in World War II, he and Drs. Strachan and Suitor established the first anesthesiology service at Springfield and Wesson Women's hospital. He leaves his wife, Virginia, and four daughters, Diane, Judith, Susan, and Nancy. ■

Announcing

Care and Management of the HIV/AIDS Patient: A Course for Primary Care Providers

Thursday Evening, November 4 through Saturday November 6, 1993

Enfield, Connecticut

Objectives:
- to discuss state-of-art HIV information;
- to develop skills for caring for persons with HIV;
- to explore the emotional impact of caring for people with HIV/AIDS
- to develop skills for teaching about HIV

Topics:
• Overview of HIV disease • Risk Assessment, Testing and Counseling • Clinical Trials • Opportunistic Infections • Ambulatory Care/ Management of HIV • Management of End-Stage HIV • Health Care Worker Risk • Substance Use and HIV • Living with Dying • Legal and Ethical Issues

The format for this intensive course is focused didactic sessions and small group discussions with HIV-positive resource faculty.

Info: Kelly Fattman, Project Coordinator, NE AIDS ETC, (617) 735-2048

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